FOR BHF USE

LL1

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

2013
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2013)

I. IDPH License ID Number: 0046680

Facility Name: Helia Hlthcare of Greenville

Address: 400 E Hillview Ave (Number) | Greenville (City) | 62246 (Zip Code)

County: Bond

Telephone Number: (618) 664-1622 **Fax #** (618) 664-1283

HFS ID Number:

Date of Initial License for Current Owners: 02/01/04

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Cindy A. Tefteller **Telephone Number:** (618)465-7717
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/13 to 12/31/13 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) (Date)
(Type or Print Name) Michael Parentin
(Title) Chief Financial Officer

Paid Preparer

(Signed) See Accountant's Compilation Report (Date)
(Print Name and Title) Cindy A. Tefteller
(Firm Name & Address) C.J. Schlosser & Company, L.L.C.
233 E. Center Drive, Alton, IL 62002
(Telephone) (618)465-7717 Fax # (618)465-7710

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Helia Hlthcare of Greenville # 0046680 Report Period Beginning: 1/1/13 Ending: 12/31/13

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	90	Skilled (SNF)	90	32,850	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	90	TOTALS	90	32,850	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	15,913	7,832	2,355	26,100	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	15,913	7,832	2,355	26,100	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 79.45%

D. How many bed-hold days during this year were paid by the Department?
None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 12/31/03

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 12/31/03 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 34 and days of care provided 2,036

Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/13 Fiscal Year: 12/31/13

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Helia Hlthcare of Greenville # 0046680 Report Period Beginning: 1/1/13 Ending: 12/31/13

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	116,534	12,266	5,603	134,403		134,403		134,403			1
2	Food Purchase		139,781		139,781		139,781	(196)	139,585			2
3	Housekeeping	115,604	17,943	700	134,247		134,247		134,247			3
4	Laundry	26,517	10,206		36,723		36,723		36,723			4
5	Heat and Other Utilities			87,282	87,282		87,282	(8,668)	78,614			5
6	Maintenance	32,978	25,813	31,827	90,618		90,618		90,618			6
7	Other (specify):*											7
8	TOTAL General Services	291,633	206,009	125,412	623,054		623,054	(8,864)	614,190			8
	B. Health Care and Programs											
9	Medical Director			9,600	9,600		9,600		9,600			9
10	Nursing and Medical Records	1,013,140	90,146	12,849	1,116,135		1,116,135	6,312	1,122,447			10
10a	Therapy	40	1,219		1,259		1,259		1,259			10a
11	Activities	38,090	7,272	3,301	48,663		48,663		48,663			11
12	Social Services	34,425	48	2,090	36,563		36,563		36,563			12
13	CNA Training											13
14	Program Transportation			1,829	1,829		1,829		1,829			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,085,695	98,685	29,669	1,214,049		1,214,049	6,312	1,220,361			16
	C. General Administration											
17	Administrative	77,497		190,300	267,797		267,797	(160,095)	107,702			17
18	Directors Fees											18
19	Professional Services			23,043	23,043		23,043	13,239	36,282			19
20	Dues, Fees, Subscriptions & Promotions			36,434	36,434		36,434	(25,020)	11,414			20
21	Clerical & General Office Expenses		8,188	43,855	52,043		52,043	184,906	236,949			21
22	Employee Benefits & Payroll Taxes			266,694	266,694		266,694	24,490	291,184			22
23	Inservice Training & Education											23
24	Travel and Seminar			3,955	3,955		3,955	5,637	9,592			24
25	Other Admin. Staff Transportation			5,207	5,207		5,207	4,221	9,428			25
26	Insurance-Prop.Liab.Malpractice			32,731	32,731		32,731	2,414	35,145			26
27	Other (specify):*											27
28	TOTAL General Administration	77,497	8,188	602,219	687,904		687,904	49,792	737,696			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,454,825	312,882	757,300	2,525,007		2,525,007	47,240	2,572,247			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Helia Hlthcare of Greenville #0046680 Report Period Beginning: 1/1/13 Ending: 12/31/13

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			25,285	25,285		25,285	5,171	30,456			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			92,303	92,303		92,303	(26,279)	66,024			32
33	Real Estate Taxes			24,000	24,000		24,000	37	24,037			33
34	Rent-Facility & Grounds			204,000	204,000		204,000	10,432	214,432			34
35	Rent-Equipment & Vehicles			7,584	7,584		7,584		7,584			35
36	Other (specify):* Loss on Disposal			112	112		112		112			36
37	TOTAL Ownership			353,284	353,284		353,284	(10,639)	342,645			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		111,372	271,308	382,680		382,680		382,680			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			186,972	186,972		186,972		186,972			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		111,372	458,280	569,652		569,652		569,652			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,454,825	424,254	1,568,864	3,447,943		3,447,943	36,601	3,484,544			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Helia Hlthcare of Greenville # 0046680 Report Period Beginning: 1/1/13 Ending: 12/31/13

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(8,883)	5		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	261	30		9
10	Interest and Other Investment Income	(26,279)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(196)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment	(1,515)	21		19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(1,721)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(21,028)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(4,678)	20		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (64,039)		$	30

BHF USE ONLY									
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	100,640		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 100,640		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 36,601		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Helia Hlthcare of Greenville

ID# 0046680

Report Period Beginning: 1/1/13

Ending: 12/31/13

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Eliminate Gifts and Flowers	$ (4,613)	20	1
2	Eliminate Chamber of Commerce Dues	(65)	20	2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(4,678)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Helia Hlthcare of Greenville # 0046680 Report Period Beginning: 1/1/13 Ending: 12/31/13

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(196)	0	0	0	0	0	0	0	0	0	0	(196)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(8,883)	215	0	0	0	0	0	0	0	0	0	(8,668)	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(9,079)	215	0	0	0	0	0	0	0	0	0	(8,864)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	6,312	0	0	0	0	0	0	0	0	0	6,312	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	6,312	0	0	0	0	0	0	0	0	0	6,312	16
	C. General Administration													
17	Administrative	0	(160,095)	0	0	0	0	0	0	0	0	0	(160,095)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(1,721)	14,960	0	0	0	0	0	0	0	0	0	13,239	19
20	Fees, Subscriptions & Promotions	(25,706)	686	0	0	0	0	0	0	0	0	0	(25,020)	20
21	Clerical & General Office Expenses	(1,515)	186,421	0	0	0	0	0	0	0	0	0	184,906	21
22	Employee Benefits & Payroll Taxes	0	24,490	0	0	0	0	0	0	0	0	0	24,490	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	5,637	0	0	0	0	0	0	0	0	0	5,637	24
25	Other Admin. Staff Transportation	0	4,221	0	0	0	0	0	0	0	0	0	4,221	25
26	Insurance-Prop.Liab.Malpractice	0	2,414	0	0	0	0	0	0	0	0	0	2,414	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(28,942)	78,734	0	0	0	0	0	0	0	0	0	49,792	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(38,021)	85,261	0	0	0	0	0	0	0	0	0	47,240	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Helia Hlthcare of Greenville # 0046680 **Report Period Beginning:** 1/1/13 **Ending:** 12/31/13

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	261	4,910	0	0	0	0	0	0	0	0	0	5,171	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(26,279)	0	0	0	0	0	0	0	0	0	0	(26,279)	32
33	Real Estate Taxes	0	37	0	0	0	0	0	0	0	0	0	37	33
34	Rent-Facility & Grounds	0	10,432	0	0	0	0	0	0	0	0	0	10,432	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(26,018)	15,379	0	0	0	0	0	0	0	0	0	(10,639)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(64,039)	100,640	0	0	0	0	0	0	0	0	0	36,601	45

Facility Name & ID Number Helia Hlthcare of Greenville # 0046680 Report Period Beginning: 1/1/13 Ending: 12/31/13

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Stephen P. Miller	100%	Helia Healthcare of Belleville	Belleville, IL	Bridgemark Healthcare	St. Louis, MO	Management Co.
		Helia Healthcare of Benton	Benton, IL	Helia Healthcare Services	Benton, IL	Laundry, Maint.
		Helia Healthcare of Carbondale	Carbondale, IL	Bridgemark Employer Services	St. Louis, MO	Human Resources
		Helia Healthcare of Champaign	Champaign, IL	Bridgemark Medical Supply	St. Louis, MO	Medical Supplies
		Helia Healthcare of Energy	Energy, IL			
		Helia Healthcare of Olney	Olney, IL			
		Frankfort Healthcare & Rehab Center	West Frankfort, IL			

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	5	Utilities	$	Bridgemark Healthcare, LLC	100.00%	$ 215	$ 215	1
2	V	10	Nursing & Medical Records		Bridgemark Healthcare, LLC	100.00%	6,312	6,312	2
3	V	17	Administrative	190,300	Bridgemark Healthcare, LLC	100.00%	30,205	(160,095)	3
4	V	19	Professional Services		Bridgemark Healthcare, LLC	100.00%	14,960	14,960	4
5	V	20	Dues, Subscriptions		Bridgemark Healthcare, LLC	100.00%	686	686	5
6	V	21	Clerical & General Office		Bridgemark Healthcare, LLC	100.00%	186,421	186,421	6
7	V	22	Employee Benefits & Payroll Taxes		Bridgemark Healthcare, LLC	100.00%	24,490	24,490	7
8	V	24	Travel & Seminar		Bridgemark Healthcare, LLC	100.00%	5,637	5,637	8
9	V	25	Admin Staff Transportation		Bridgemark Healthcare, LLC	100.00%	4,221	4,221	9
10	V	26	Insurance		Bridgemark Healthcare, LLC	100.00%	2,414	2,414	10
11	V	30	Depreciation		Bridgemark Healthcare, LLC	100.00%	4,910	4,910	11
12	V	33	Real Estate Taxes		Bridgemark Healthcare, LLC	100.00%	37	37	12
13	V	34	Rent		Bridgemark Healthcare, LLC	100.00%	10,432	10,432	13
14	Total			$ 190,300			$ 290,940	$ * 100,640	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Helia Hlthcare of Greenville # 0046680 Report Period Beginning: 1/1/13 Ending: 12/31/13

VII. RELATED PARTIES

A. (Continued) **Enter below the names of ALL owners and related organizations (parties) as defined in the instructions**

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Helia Southbelt Healthcare	Belleville, IL				1
2			Hillside Rehab & Care Center	Yorkville, IL				2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Helia Hlthcare of Greenville # 0046680 Report Period Beginning: 1/1/13 Ending: 12/31/13

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Stephen P. Miller	Owner	Administrative	100.00	271,384	5.01	10.02	Distribution	$ 30,205	17,8	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 30,205		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Helia Hlthcare of Greenville # 0046680 Report Period Beginning: 1/1/13 Ending: 12/31/13

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Bridgemark Healthcare, LLC
Street Address: 11970 Borman Drive, Suite 100
City / State / Zip Code: St. Louis, MO 63146
Phone Number: ((314)431-0511
Fax Number: ((314)754-9176

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	Utilities	Resident Days	260,600	10	$ 2,150	$	26,100	$ 215	1
2	10	Nursing & Medical Records	Resident Days	260,600	10	63,025	63,025	26,100	6,312	2
3	17	Owners Compensation	Resident Days	260,600	10	301,589		26,100	30,205	3
4	19	Professional Fees	Resident Days	260,600	10	149,373		26,100	14,960	4
5	20	Dues, Subscriptions	Resident Days	260,600	10	6,850		26,100	686	5
6	21	Salaries-Other	Resident Days	260,600	10	1,295,190	1,295,190	26,100	129,718	6
7	21	Clerical & Office Supplies	Resident Days	260,600	10	566,161		26,100	56,703	7
8	22	Emp Benefits & Payroll Taxes	Resident Days	260,600	10	244,527		26,100	24,490	8
9	24	Seminars	Resident Days	260,600	10	56,285		26,100	5,637	9
10	25	Admin Staff Travel	Resident Days	260,600	10	42,147		26,100	4,221	10
11	26	Insurance	Resident Days	260,600	10	24,107		26,100	2,414	11
12	30	Depreciation	Resident Days	260,600	10	49,028		26,100	4,910	12
13										13
14	33	Real Estate Taxes	Resident Days	260,600	10	374		26,100	37	14
15	34	Building Rent	Resident Days	260,600	10	95,749		26,100	9,590	15
16	34	Rental-Storage Unit	Resident Days	260,600	10	8,407		26,100	842	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 2,904,962	$ 1,358,215		$ 290,940	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Helia Hlthcare of Greenville # 0046680 Report Period Beginning: 1/1/13 Ending: 12/31/13

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	MidCap Funding I, LLC		X			10/22/09				Variable	92,303	6
7												7
8												8
9	TOTAL Facility Related						$	$			$ 92,303	9
	B. Non-Facility Related*											
10	Interest Income		X								(26,279)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (26,279)	14
15	TOTALS (line 9+line14)						$	$			$ 66,024	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ None Line # N/A

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Helia Hlthcare of Greenville # 0046680 **Report Period Beginning:** 1/1/13 **Ending:** 12/31/13

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2012 report. **Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$		1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	24,000	2
3. Under or (over) accrual (line 2 minus line 1).	$	24,000	3
4. Real Estate Tax accrual used for 2013 report. (Detail and explain your calculation of this accrual on the lines below.)	$		4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND** $ ____ **For** ____ **Tax Year.** (Attach a copy of the real estate tax appeal board's decision.)	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	24,000	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2008	32,741	8
2009	34,391	9
2010	34,608	10
2011	35,557	11
2012	35,702	12

24,000 Line 7, Real Estate Taxes included in Lease Payments
37 Bridgemark Healthcare Allocation
24,037 Total Schedule V, Line 33

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2012	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.** This denial must be no more than four years old at the time the cost report is filed.

SEE ACCOUNTANTS' COMPILATION REPORT

2012 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Helia Hlthcare of Greenville COUNTY Bond

FACILITY IDPH LICENSE NUMBER 0046680

CONTACT PERSON REGARDING THIS REPORT Michael Parentin

TELEPHONE (314)431-0511 FAX #: (314)754-9176

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2012 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2012.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	05-10-14-330-001	Long Term Care	$ 35,701.58	$ 35,701.58
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 35,701.58	$ 35,701.58

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES X NO

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2012 tax bills which were listed in Section A to this statement. Be sure to use the 2012 tax bill which is normally paid during 2013.

PLEASE NOTE: ***Payment information from the Internet*** or otherwise is ***not considered acceptable tax bill documentation*** . Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.

Facility Name & ID Number Helia Hlthcare of Greenville # 0046680 Report Period Beginning: 1/1/13 Ending: 12/31/13

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 20,000 B. General Construction Type: Exterior Brick Frame Wood Number of Stories 1

C. Does the Operating Entity? [ ] (a) Own the Facility [ ] (b) Rent from a Related Organization. [X] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Section N/A			$	1
2					2
3	TOTALS			$	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Helia Hlthcare of Greenville # 0046680 Report Period Beginning: 1/1/13 Ending: 12/31/13

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Generator			2004	4,102		5			4,102	9
10	Shed			2004	752		5			752	10
11	Generator			2004	2,100		5			2,100	11
12	Generator Freight			2004	1,134		5			1,134	12
13	Fire System Repair			2004	1,229		10	123	123	1,229	13
14	Shed			2004	1,383		10	138	138	1,383	14
15	Sidewalk			2005	2,450	245	10	245		2,124	15
16	Sidewalk			2005	1,096	110	10	110		949	16
17	Hot Water Heater			2006	1,175	118	10	118		881	17
18	Concrete			2006	946		5			946	18
19	A/C Heat Unit			2006	1,626		5			1,626	19
20	Kitchen Exhaust System			2007	5,940	594	10	594		3,762	20
21	A/C Heat Unit			2007	1,556		5			1,556	21
22	Wing Remodel Project			2007	6,811	341	20	341		2,043	22
23	Wing Remodel Project			2008	107,282	5,364	20	5,364		26,820	23
24	New Center B-wing Call System			2008	5,157	516	10	516		2,836	24
25	Stepsmart Flooring - Carpet			2008	10,301	1,888	5	1,888		10,301	25
26	Call System			2008	2,998		10	300	300	1,649	26
27	Signs			2008	1,182		10	118	118	591	27
28	Wing Remodeling, Doors, Flooring, Railings & Nurses Station			2009	20,539	1,369	15	1,369		6,774	28
29	Heating & A/C			2009	5,995	400	15	400		1,799	29
30	Cable Installation			2009	3,500	350	10	350		1,546	30
31	Parking Lot			2011	26,500	1,325	20	1,325		3,423	31
32	3 A/C Units			2011	1,976	395	5	395		955	32
33	Back-Up Generator Improvements			2011	2,853	571	5	571		1,331	33
34	Frigidaire PTAC- Allied Natl			2013	1,157	51	15	51		51	34
35	Flooring/Carpet - Dining, Living, Activities			2013	15,338	1,023	5	1,023		1,023	35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Helia Hlthcare of Greenville # 0046680 Report Period Beginning: 1/1/13 Ending: 12/31/13

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Related Party Allocation-Bridgemark Healthcare		$	$		$	$	$	37
38	New Office Build-Out	2011	13,602		20	720	720	1,767	38
39	Conference Rm Chair Rail & Paint	2012	154		5	31	31	41	39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 250,834	$ 14,660		$ 16,090	$ 1,430	$ 85,494	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Helia Hlthcare of Greenville # 0046680 Report Period Beginning: 1/1/13 Ending: 12/31/13

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 56,268	$ 5,778	$ 8,916	$ 3,138	3-15	$ 27,268	71
72	Current Year Purchases	21,346	1,417	1,881	464	3-15	1,881	72
73	Fully Depreciated Assets	15,642					15,642	73
74								74
75	TOTALS	$ 93,256	$ 7,195	$ 10,797	$ 3,602		$ 44,791	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Related Party Allocation-Bridgemark			$ 1,331	$	$ 139	$ 139	5	$ 1,331	76
77	Facility	Bus	2013	23,522	3,430	3,430		4	3,430	77
78										78
79										79
80	TOTALS			$ 24,853	$ 3,430	$ 3,569	$ 139		$ 4,761	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 368,943	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 25,285	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 30,456	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 5,171	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 135,046	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Section N/A	$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92	Section N/A	$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Helia Hlthcare of Greenville # 0046680 Report Period Beginning: 1/1/13 Ending: 12/31/13

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: First Healthcare Associates

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [X] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:		90		$ 204,000			3
4	Additions							4
5								5
6								6
7	TOTAL		90		$ 204,000 **			7

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2014	$
13.	/2015	$
14.	/2016	$

8. List separately any amortization of lease expense included on page 4, line 34. N/A
This amount was calculated by dividing the total amount to be amortized N/A
by the length of the lease N/A .

9. Option to Buy: [ ] YES [X] NO Terms: *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO

16. Rental Amount for movable equipment: $ 7,584 Description: See Attached Schedule
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Section N/A		$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Helia Hlthcare of Greenville # 0046680 Report Period Beginning: 1/1/13 Ending: 12/31/13

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Helia Hlthcare of Greenville

STATE OF ILLINOIS
0046680 Report Period Beginning: 1/1/13 Ending: 12/31/13

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a,2	hrs	$		$	$ 290		$ 290	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a,2	hrs				929		929	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39,2	# of prescrpts				86,141		86,141	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify): Wound Care, Oxygen,	39,2					25,231		25,231	12
13	Physical, Occupational & Speech Therapy Other (specify): Lab & X-Ray	39,3				271,308			271,308	13
14	TOTAL			$		$ 271,308	$ 112,591		$ 383,899	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Facility Name & ID Number Helia Hlthcare of Greenville **#** 0046680 **Report Period Beginning:** 1/1/13 **Ending:** 12/31/13

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/13 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 4,846	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (46,800))	838,279		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	155		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 843,280	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	244,530		15
16	Equipment, at Historical Cost	90,924		16
17	Accumulated Depreciation (book methods)	(121,525)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 213,929	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,057,209	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 455,280	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	90,886		30
31	Accrued Taxes Payable (excluding real estate taxes)	4,369		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Due to Bridgemark Healthcare	709,233		36
37	Accrued Assessment Tax Payable	38,247		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,298,015	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Note Payable - Owner	234,983		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 234,983	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,532,998	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (475,789)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,057,209	$	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Helia Hlthcare of Greenville # 0046680 Report Period Beginning: 1/1/13 Ending: 12/31/13

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (1,319,232)	1
2	Restatements (describe):		2
3	**Adjustments made after c/r filed:**		3
4	**Prior year accounts receivable adjustments**	1,347	4
5	**Prior year w/c & unemployment adjustments**	7,259	5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (1,310,626)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	834,837	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 834,837	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (475,789)	24 *

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Helia Hlthcare of Greenville # 0046680 Report Period Beginning: 1/1/13 Ending: 12/31/13

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,679,849	1
2	Discounts and Allowances for all Levels	3,536	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,683,385	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	145,903	6
7	Oxygen	9,488	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 155,391	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	26,279	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 26,279	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous	5,225	28
28a	Forgiveness of Note Payable	412,500	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 417,725	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,282,780	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	623,054	31
32	Health Care	1,214,049	32
33	General Administration	687,904	33
	B. Capital Expense		
34	Ownership	353,284	34
	C. Ancillary Expense		
35	Special Cost Centers	382,680	35
36	Provider Participation Fee	186,972	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,447,943	40
41	**Income before Income Taxes (line 30 minus line 40)****	834,837	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 834,837	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 1,749,285	44
45	Private Pay - Net Inpatient Revenue	1,029,677	45
46	Medicare - Net Inpatient Revenue	826,184	46
47	Other-(specify) Insurance	66,372	47
48	Other-(specify) Hospice	11,867	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 3,683,385	49

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Not Complete If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

******Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Helia Hlthcare of Greenville # 0046680 Report Period Beginning: 1/1/13 Ending: 12/31/13

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,008	2,124	$ 53,584	$ 25.23	1
2	Assistant Director of Nursing	324	368	10,091	27.42	2
3	Registered Nurses	7,460	7,800	189,767	24.33	3
4	Licensed Practical Nurses	12,445	12,987	243,320	18.74	4
5	CNAs & Orderlies	41,306	43,870	479,954	10.94	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	3,042	3,381	38,090	11.27	10
11	Social Service Workers	1,822	1,998	34,425	17.23	11
12	Dietician					12
13	Food Service Supervisor	1,762	2,014	28,620	14.21	13
14	Head Cook					14
15	Cook Helpers/Assistants	8,970	9,545	87,914	9.21	15
16	Dishwashers					16
17	Maintenance Workers	2,074	2,207	32,978	14.94	17
18	Housekeepers	10,115	10,758	115,604	10.75	18
19	Laundry	2,123	2,395	26,517	11.07	19
20	Administrator	1,847	2,022	77,497	38.33	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,971	2,152	36,464	16.94	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	97,269	103,621	$ 1,454,825 *	$ 14.04	34

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$ 5,603	1,3	35
36	Medical Director		9,600	9,3	36
37	Medical Records Consultant		2,932	10,3	37
38	Nurse Consultant				38
39	Pharmacist Consultant		3,045	10,3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant		3,301	11,3	44
45	Social Service Consultant		2,090	12,3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 26,571		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	Section N/A	$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number Helia Hlthcare of Greenville # 0046680 Report Period Beginning: 1/1/13 Ending: 12/31/13

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Heather Stich	Administrator	0	$ 77,497
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 77,497

B. Administrative - Other

Description	Amount
Bridgemark Healthcare LLC-Management Fees	$ 190,300
TOTAL (agree to Schedule V, line 17, col. 3)	$ 190,300
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
C.J. Schlosser & Company, LLC	Accounting Services	$ 5,240
Ceridian	Payroll Processing	12,195
Kramer & Frank PC	Collections - Eliminated	1,721
Personnel Planners, Inc.	Unemployment Consultant	2,560
Much Shelist	Legal Fees	637
CMS	CMS Revalidation Fees	532
FRF	Accounting Services	158
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $5,000, attach copy of invoices.)		$ 23,043

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 47,373
Unemployment Compensation Insurance	81,382
FICA Taxes	109,829
Employee Health Insurance	20,929
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
401(k) Match	2,532
Employee Benefits	2,173
Uniforms	482
Other Employee Insurance	1,994
Related Party Allocation-Bridgemark	24,490
TOTAL (agree to Schedule V, line 22, col.8)	$ 291,184

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
Section N/A		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,990
Advertising: Employee Recruitment	4,953
Health Care Worker Background Check	
(Indicate # of checks performed)	1,601
Patient Background Checks	
Dues & Subscriptions	610
Late Fees	1,574
Miscellaneous Licenses & Fees	
Related Party Allocation-Bridgemark	686
Advertising	21,028
Less: Public Relations Expense	( )
Non-allowable advertising	(21,028)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 11,414

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	1,471
Seminar Expense	2,484
Related Pary Allocation-Bridgemark	5,637
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 9,592

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Helia Hlthcare of Greenville # 0046680 Report Period Beginning: 1/1/13 Ending: 12/31/13

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1	Schedule N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Helia Hlthcare of Greenville # 0046680 Report Period Beginning: 1/1/13 Ending: 12/31/13

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **No**
If YES, give association name and amount. **N/A**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **3-15 Yrs**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **10,841** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **186,972**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **N/A**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **N/A** Has any meal income been offset against related costs? **No** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **N/A**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **Yes**

(19) If total legal fees are in excess of $5,000, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees

Helia Healthcare of Greenville
Attachment to Schedule XII B
Equipment Rentals
12/31/2013

	Description	
16A	Nursing Equipment	$ 3,856
16B	Dietary Equipment	158
16C	Copier Lease	3,570
		$ 7,584

ATTACHMENT TO SCHEDULE XIX, SECTION G

E OF EMPLOYEE NDING SEMINAR	JOB TITLE	DATE	LOCATION	SEMINAR TITLE	SEMINAR SPONSOR	SEMINAR COST	TRAVEL/ LODGING COST
All Nursing Staff		5/3/2013	Helia Of Greenville	Handwashing - Inservi	Deb Mullen	100.00	
Kaitlin Roper	D.O.N.	May-13	Springfield, IL	Restorative Nursing P	Pathway Health Servic	899.00	692.64
Penny Wilson	MDS	1/30/2013	Springfield, IL	MDS Training	IHCA	550.00	268.80
Kari Wehrle	Cook	21-Feb	Vandalia, IL	Sanitation Course	Joyce Stork	130.00	
Kari Wehrle	Cook	8-Apr		FSSMC certificate	IDPH	35.00	
All Nursing Staff		6-Aug	Helia of Greenville	CPR Training	Ryan Cunningham	175.00	
All Nursing Staff		20-Aug	Helia of Greenville	CPR Training	Ryan Cunningham	275.00	
Heather Stich	Administrator	1-Oct	Springfield, Il	Pioneer Coalition	IL. Pioneer Coalition	160.00	254.54
Kaitlin Roper	D.O.N.	1-Oct	Springfield, Il	Pioneer Coalition	IL. Pioneer Coalition	160.00	254.54
						2,484.00	1,470.52
					Travel/Lodging	1,470.52	
					Home Office Allocatio	5,637.00	
						9,591.52	

Bridgemark Healthcare
Home Office and Related Party Salaries
12/31/2013

	Hours/wk	Compensation	Total Salaries and Wage Related Costs
Owners Compensation	50.00	301,589	
	50.00	301,589	301,589

Allocation by Home:				Compensation Other Homes
Belleville	11.61%	5.80	35,001	266,588
Benton	9.85%	4.92	29,704	271,885
Carbondale	8.21%	4.11	24,773	276,816
Champaign	10.34%	5.17	31,175	270,414
Energy	10.32%	5.16	31,138	270,451
Southbelt	15.72%	7.86	47,399	254,190
Frankfort	6.14%	3.07	18,528	283,061
Greenville	10.02%	5.01	30,205	271,384
Hillside	8.20%	4.10	24,718	276,871
Olney/Richland	9.60%	4.80	28,947	272,642
	100.00%	50.00	301,589	